VITALITY DENTAL ARTS

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

☐ Please enroll me in auto-pay and charge my monthly account balance to my credit card on the 1st / 15th / last business day (circle one) of every month. Please note: All payments are due by the last day of each month.

☐ I would not like to enroll in auto-pay at this time. Please keep my credit card on file to be used for future payments. If my payment is not received by the last day of each month, you are authorized to charge my outstanding balance.

Office Name:_____
Address:_____
Phone: _____
Email:_____

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Security Code_____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Vitality Dental Arts to charge my credit card above for purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

Please e-mail this form back to **ashley.s@vitalitydentalarts.com** or mail to:

Vitality Dental Arts
Attn: Accounting
505 Davis Rd.
Elgin, IL 60123

Check or other method of payment will still be accepted prior to the statement due date, but please note that your credit card will be charged if payment isn't received by the last day of each month. If at any time an automatic payment transaction cannot be completed or your credit card is declined, your account will be placed on temporary hold.